LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD: _____

HAS HE/SHE HAD ANY RECENT ILLNESS? ☐ YES ☐ NO IF YES, EXPLAIN: _____

_____

ANY ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE LIST: _____

IF YES, ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTION

WHAT IS THE CHILD'S EATING HABIT? _____
FAVORITE FOODS: _____
STRONG DISLIKES: _____

BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN
(ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES)

First Visit – two months of age: / /	Fourth Visit – 12 months of age: / /
☐ **Diphtheria**	☐ **Measles**
☐ **Pertussis**	☐ **Mumps**
☐ **Tetanus**	☐ **Rubella**
☐ **Polio**	☐ **Meningococcal C Conjugate**
☐ **Haemophilus Influenza Type b (hib)**	☐ **Varicella (chicken pox)**
☐ **Hepatitis B**	
☐ **Pneumococcal Conjugate**	Fifth Visit – 12 months after third visit: / /
☐ **Meningococcal C Conjugate**	☐ **Diphtheria**
	☐ **Pertussis**
Second Visit – two months after first visit: / /	☐ **Tetanus**
☐ **Diphtheria**	☐ **Polio**
☐ **Pertussis**	☐ **Haemophilus Influenza Type b (hib)**
☐ **Tetanus**	☐ **Measles, Mumps, Rubella**
☐ **Polio**	☐ **Pneumococcal Conjugate**
☐ **Haemophilus Influenza Type b (hib)**	
☐ **Hepatitis B**	4 to 6 years of age: / /
☐ **Pneumococcal Conjugate**	☐ **Diphtheria**
	☐ **Pertussis**
Third Visit – two months after second visit: / /	☐ **Tetanus**
☐ **Diphtheria**	☐ **Polio**
☐ **Pertussis**	☐ **Varicella (chicken pox)**
☐ **Tetanus**	
☐ **Polio**	Other Immunizations:
☐ **Haemophilus Influenza Type b (hib)**	/ /
☐ **Hepatitis B**	/ /
☐ **Pneumococcal Conjugate**	/ /

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ACCIDENT OR ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

CAREGIVER SIGNATURE _____

DATE _____

CHILD CARE REGISTRATION FORM

(Include a photo of child)

FACILITY

NAME OF FACILITY _____ DATE OF ENROLLMENT / /

CHILD

NAME OF CHILD _____

SURNAME GIVEN MIDDLE NAME

NAME CHILD RESPONDS TO _____ SEX: ☐ M ☐ F

ADDRESS _____

DATE OF BIRTH / / FIRST DAY OF ATTENDANCE / / END DATE / /

PARENT/GUARDIAN

NAME _____

PLACE OF WORK _____ PHONE _____ LOCAL _____

HOME ADDRESS _____ PHONE _____ HOURS OF WORK _____

NAME _____

PLACE OF WORK _____ PHONE _____ LOCAL _____

HOME ADDRESS _____ PHONE _____ HOURS OF WORK _____

E-MAIL _____

MEDICAL INFORMATION

FAMILY DOCTOR _____ PHONE _____

MEDICAL INSURANCE PLAN NUMBER _____ DATE EFFECTIVE / /

ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) AUTHORIZED TO PICK UP CHILD FROM FACILITY

NAME _____ PHONE _____

NAME _____ PHONE _____

NAME _____ PHONE _____

PERSONS NOT PERMITTED ACCESS TO CHILD

NAME _____ PHONE _____

NAME _____ PHONE _____

ARE THERE CUSTODY ORDERS? ☐ YES ☐ NO IF YES, ATTACH DOCUMENTATION

NAMES OF OTHER CHILDREN LIVING AT HOME

NAME _____ DATE OF BIRTH / /

NAME _____ DATE OF BIRTH / /

HAS CHILD HAD PREVIOUS EXPERIENCE AWAY FROM HOME? (DAY CARE, PRESCHOOL, SUNDAY SCHOOL, ETC.) ☐ YES ☐ NO

IF YES, EXPLAIN: _____

WHERE? _____ DATES OF ATTENDANCE: _____

DO YOU THINK YOUR CHILD FEELS COMFORTABLE LEAVING PARENTS? ☐ YES ☐ NO

EXPLAIN: _____

DOES THIS CHILD HAVE ANY KNOWN HEALTH PROBLEMS/MEDICAL DISABILITIES? ☐ YES ☐ NO

IF YES, ATTACH DOCUMENTATION